SightLine Laser Eye Center

REFRACTIVE PRE-PROCEDURE EVALUATION

Please fax this form as soon as possible to 724-933-6051.

REFERRING DOCTOR ______________________________ EXAM DATE ______________________________

PATIENT NAME ______________________________ SEX: □ M □ F D.O.B. ____________________

PREFERRED PHONE ______________________________ PROCEDURE DATE (if scheduled) ______________

PREFERRED PROCEDURE TYPE □ LASIK □ PRK □ ICL □ RLE □ ENHANCEMENT

Co-management: Patient chose to have post operative care at □ our office □ Sightline.

Payment for co-management: □ We will collect our fee □ Process through Cofi

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Was a cycloplegic refraction done? □ Yes □ No If not, patient scheduled on: ___________

Was a dilated fundus exam performed? □ Yes □ No

Does the patient have any **ALLERGIES TO MEDICATIONS** including analgesics, **HEALTH CONDITIONS (including pregnancy or nursing), CURRENT MEDICATIONS (including Accutane and Cordarone), PAST OR PRESENT OCULAR CONDITIONS (including Keratoconus for patient or immediate family member)** that may adversely impact the patient's procedure, outcome, or long-term ocular health? □ Yes □ No If yes, list:

BASEMENT MEMBRANE DYSTROPHY? □ Yes □ No **DRY EYE CONDITION?** □ Yes □ No If yes, explain:

REFRACTIVE STABILITY ACHIEVED? □ Yes □ No **RECENT CONTACT LENS WEAR?** □ Yes □ No Type:
(less than 0.50D change in 12 months)

KERATOMETRY OD______________ @ __________ deg. by ______________ @ __________ deg.

OS______________ @ __________ deg. by ______________ @ __________ deg.

Please enter either: □ your recommended treatment or □ your most recent refraction

OD Sphere __________ Cyl. __________ Axis __________ VA __________ **Pachymetry** _________

OS Sphere __________ Cyl. __________ Axis __________ VA __________ _________

Desired **OUTCOME** (This will be added to or subtracted from the above prescription to achieve the desired outcome.)

OD: □ Emmetropia □ Myopia If so, what power? __________________

OS □ Emmetropia □ Myopia If so, what power? __________________

COMMENTS:

______ Report Faxed to SightLine Signature ______________________________

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